



## ***Texas Department of Insurance***

### ***Division of Workers' Comp***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

MEMORIAL HERMANN HOSPITAL SYSTEM  
3200 SOUTHWEST FRWY SUTIE 2200  
HOUSTON TX 77027

#### **Respondent Name**

ACE AMERICAN INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 15

#### **MFDR Tracking Number**

M4-07-2489-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "The hospital's records reflect this admission is trauma and the coding of the UB92 as trauma. Therefore, the expected reimbursement is based upon the hospital's fair and reasonable charges, usual and customary which is in the amount of its billed charges of \$96,166.40. The hospital received an underpayment of \$34,769.84 leaving an additional reimbursement due of \$61,396.56."

**Amount in Dispute:** \$61,396.56

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** "Provider has furnished no evidence showing that the amount of reimbursement it seeks is consistent with the statutory mandate to achieve effective medical cost control, or that the amount does not exceed the fee charged for similar treatment of an individual of an equivalent standard of living and paid by someone acting on that individual's behalf, or that the amount is based, in part, on the increased security of payment afforded by the Act. Likewise, Provider has no evidence which establishes that Carrier's level of reimbursement does not meet these statutory standards for reimbursement; or that the overall reimbursement is insufficient in this case. In fact, Provider has submitted no evidence at all. Accordingly, Provider has not met its burden of proof to show that the amount of reimbursement it seeks is 'fair and reasonable,' within the meaning of section 413.011 of the Act. Therefore, Provider is not entitled to additional reimbursement."

Response Submitted by: James M. Loughlin, Stone Loughlin & Swanson, LLP, P.O. Box 30111 Austin, TX 78755

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 23, 2005 through January 7, 2006	Outpatient Surgery	\$61,396.56	\$0.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on December 21, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 Texas Register 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 29, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W1-Workers Compensation state fee schedule adjustment.
  - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
  - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
  - 42-Charges exceed our fee schedule or maximum allowable amount.
  - W3-Additional payment made on appeal/reconsideration.

### **Findings**

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 813.44. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. The requestor did not submit a copy of the operative report, anesthesia record, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
3. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- The requestor's position statement asserts that "The hospital's records reflect this admission is trauma and the coding of the UB92 as trauma. Therefore, the expected reimbursement is based upon the hospital's fair and reasonable charges, usual and customary which is in the amount of its billed charges of \$96,166.40. The hospital received an underpayment of \$34,769.84 leaving an additional reimbursement due of \$61,396.56."
- The requestor does not discuss or explain how payment of \$61,396.56 would result in a fair and reasonable reimbursement.
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:  

"A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Manager

\_\_\_\_\_  
Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**